STATEMENT OF

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss issues related to safety and security at VA facilities.

Police matters

The Office of Security and Law Enforcement was established in December 1989 to consolidate all of the Department's security and law enforcement functions under one department-wide program. Responsibilities of the office include training VA police officers, as well as establishing policy and providing oversight for police operations at department medical centers.

Immediately following my appointment in 1989, I prepared a four-year strategic plan outlining needed improvements and a time-line for their accomplishment. This plan, which was approved by the Secretary in 1990, included goals of significantly expanding and improving training for police officers at all levels. Also addressed in the plan was expanding and improving program oversight and other goals designed to ensure improved local services. One of

the areas that required careful attention was how VA police officers would defend patients, employees, property and themselves.

Prior to 1971, VA maintained a “security guard” force. When we converted to police operations in 1971, a decision was made to equip our police officers only with a chemical irritant projector, utilizing CN (Mace) as the active ingredient. Subsequently, approximately 15 facilities were authorized to also equip their police officers with the straight stick baton because of the limited effectiveness of Mace and because of increasingly violent encounters between police officers and intruders at those locations. With these limited weapons at their disposal, VA police, at great personal risk, performed admirably and dealt successfully with most violent encounters.

Several incidents drew much attention to the fact that VA police officers were at a distinct disadvantage when faced with an armed individual --two separate incidents in the late 1980s at Brecksville, Ohio and Bronx, NY, in which three unarmed VA police officers were shot and killed in the line of duty, and in 1992 there was a serious wounding by gunfire of another police officer at VAMC Columbia, SC.

Since becoming the Secretary of Veterans Affairs, Jesse Brown has played a direct role in issues relating to security at VA facilities. In August 1995, after giving serious consideration to the various and differing opinions on the matter, Secretary Brown elected to initiate a one-year pilot project to arm police officers at no more than six VA medical centers. The purpose of the pilot is to determine the feasibility of arming officers at additional facilities. Section 904 of title 38, United States Code, authorizes the Secretary to furnish Department police officers with such weapons as the Secretary determines to be necessary and appropriate to ensure the maintenance of law and order and protection of persons and property on Department property. Following the preparation and

staffing of a VA directive, and consultation with the Attorney General and representatives of the FBI Academy, VA initiated the pilot program in September 1996. The Office of Security and Law Enforcement conducted on-site reviews and firearms training at five pilot sites: Bronx, NY; Richmond, VA; North Chicago, IL; Chicago (West Side) IL; and West Los Angeles, CA. These sites were selected because of the support of local managers and because of a desire to have as broad a geographical representation as possible.

The five pilot sites initiated the program as they completed all the prerequisites, with the first being North Chicago on September 30, 1996, and the last being Chicago West Side on January 1, 1997. We originally intended to conduct an initial evaluation of the program at the sixth month, but because of the shooting death of a physician at VAMC Jackson, MS, the Secretary directed that a preliminary evaluation be provided to him by April 1, 1997. The report of the evaluation, conducted by the Office of Security and Law Enforcement, judged the program to be successful to date. All actions taken by officers were appropriate and there was evidence that officers were exercising more vigilance in the key areas of investigative stops and car stops. Comments from staff and patients were overwhelmingly positive. Based upon this positive report, and in order to develop a broader base of experience, the Secretary decided to expand the number of facilities in the pilot program

The on-site firearm training program for the officers participating in the pilot was developed with the assistance of the Chief of the FBI Academy Firearms Training Unit, who reviewed the final training plan and concluded that our training exceeded or was equivalent to that offered by most federal agencies. Also, at our request, the Chief of the Academic Affairs Section at the FBI Academy reviewed our basic police officer training course. Although this Section does not certify or accredit basic law enforcement training, it was their conclusion

in April 1996, that VA's 160-hour basic course appeared to be consistent with the standards established at the Federal Law Enforcement Training Center and at several state academies.

Title 38 authorizes the Secretary to prescribe the scope and duration of training required for Department police officers. Immediately after my appointment, I focused attention on improving both the quality and quantity of training given to VA police. At that time there was a small, but dedicated, staff providing a basic police officer training course of only 68 hours at the Little Rock VAMC. The Department of Justice had recommended to VA that the training course be 160 hours. In August 1992, we expanded the basic police officer course to 160 hours, added highly qualified instructors in the important areas of law and human behavior, and greatly improved the classroom facilities. In the basic course, we emphasize the specialized and specific needs of policing in a health care environment and the participation of VA police officers as a part of the medical care team.

VA's law enforcement training program is now funded through the Franchise Fund and provides basic police officer training to police officers from the National Gallery of Art, the Indian Health Services of the Oglala Sioux Indian Tribe, Pine Ridge, SD, and Walter Reed Army Medical Center. These organizations have chosen our training center, in part, because of our focus on training our officers to deal with difficult persons, utilizing the minimum amount of force necessary.

Finally, I wish to emphasize that we see the firearm as another tool for the officer. We do not see that its addition, in any way, changes the philosophy that Department officers use only the minimum amount of force necessary to de-escalate violent encounters.

Controlled substances

Since the 1992 House Veterans' Affairs Committee hearing on controls over addictive drugs and drug diversion, VA has made significant progress. Working with the Office of the Inspector General, the General Accounting Office, and the Office of Security and Law Enforcement, the Veterans Health Administration has instituted regulations over the accountability of controlled substances that are more strict than any state or any other health care system's requirements. Mr. Chairman, I would like to briefly review some of the major actions taken by the Department to address the diversion issue.

In 1991, the Secretary reported controls over lower scheduled drugs as a material weakness under the Federal Managers' Financial Integrity Act report. Subsequently, a series of actions were planned to correct the material weakness. Resources were identified and approved for both the software development and the necessary hardware to support the movement to requiring perpetual inventory of all controlled substances. To improve accountability and automate manual processes, three versions of controlled substances software have been released to VA medical centers. Today all VA medical centers and clinics are required to maintain perpetual inventory of all controlled substances dispensed. These requirements will result in controls that exceed the community standards. In 1997, VA will recommend that the material weakness be closed.

To deter and detect diversion, VA required that access to controlled substances be limited within the pharmacy and that documentation be maintained regarding employees who have that access. Storing and dispensing of controlled substances must occur within locked areas and electronic access control devices must be installed on all locations within pharmacy where controlled substances are stored or dispensed. This includes all cabinets, vaults, drawers, and carts where controlled substances are stored or from which they are dispensed.

To verify the accuracy of inventories and identify any discrepancies in a timely manner, verification of all controlled substances is required every 72 hours. Prior to this requirement, inventory was verified monthly during the monthly narcotic inspection. While this verification process is time consuming, automation has offset some of the human resource requirements. There are examples where the 72-hour verification has identified discrepancies, losses and thefts. These verifications continued to support detection and deterrence of diversion.

To reduce the likelihood of diversion after an outpatient prescription is filled, a tamper proof seal must be affixed to all controlled substance prescription vials after filling the prescription, all completed prescriptions must be stored in locked cabinets, and positive patient identification and patient signature is required before the medication is handed to the patient or his/her agent.

These are just some of the actions taken as part of a comprehensive plan to improve the ability to deter and detect diversion of controlled substances within VA facilities.

VA has also taken actions to improve the ability to deter and detect the diversion of non-controlled substances from VA facilities. VA has implemented a “just-in-time” inventory and delivery system utilizing private sector prime vendor distributors. This distribution system has dramatically reduced inventories within VA pharmacies for both controlled and non-controlled substances and has removed all inventories of pharmaceuticals that were stored in VA medical center warehouses. VA has developed and implemented Drug Accountability software that will assist VA medical centers in verification of inventory. Requirements regarding verification of high cost pharmaceuticals was established in 1991 and are still in effect. Additional software development is ongoing. VA has established an interface with private sector prime vendors that will allow for the

automated downloading of goods received into VA inventory. The software is undergoing testing and planned release is in the summer of 1997. After the software is released and implemented, VA will reassess current inventory accountability requirements.

VA currently operates six Consolidated Mail Outpatient Pharmacies (CMOPS). These CMOPS dispense millions of prescriptions a year and maintain the largest inventories of pharmaceuticals in the VA system. At all the CMOPS there is a requirement that the private sector software allow VA managers to track and account for their inventory, thereby automating the process and increasing their ability to deter and detect diversion.

VA continues to review all reports of diversion received by VHA, Security and Law Enforcement, and OIG investigations. While the temptation to divert both controlled and non-controlled substances will always exist and individuals will continue to attempt diversion, VA has substantially improved its ability to deter and detect diversion. We will continue our efforts and work with all parties to identify opportunities for improvements.

VA fire departments

At the vast majority of the Department's medical centers, fire fighting services are provided by local community fire departments. When local fire fighting services do not meet VA's minimum level of requirements, VA operates in-house fire departments.

The minimum level fire fighting services acceptable for VA medical centers is an initial response from four paid firefighters and one fire fighting apparatus meeting the criteria of National Fire Protection Association Standard 1901 with a minimum pumping capacity of 750 gallons per minute. This response must be available 24 hours a day, seven days a week and must be capable of responding to the

medical center in eight minutes or less, which is equal to a distance of approximately 3-1/2 miles.

Currently only 30 VA medical centers are operating in-house fire departments, with approximately 387 FTEE. The total operating costs for all 30 fire departments for FY 1996 was $16,289,215. The majority of these remaining 30 VA fire departments are located at VA medical centers in rural areas served by small, all volunteer fire departments. While many local communities depend upon volunteer fire departments, such departments, by their nature, cannot guarantee VA's minimum level of response in a given time.

Thirty years ago, more than 65 VA medical centers operated in-house fire departments. As conditions have changed over the past several decades, local communities have expanded and their fire departments have grown in size and quality. As the local fire fighting services expanded, fire fighting responsibility was transferred from VA medical centers to the local community whenever possible. In the past ten years, 6 VA medical centers have closed their fire departments.

One of the objectives of the Under Secretary for Health's Prescription for Change is to focus management attention on VHA's key business of providing health care. With this in mind, we are exploring opportunities for contracting out fire fighting services wherever possible. However, the potential for contracting out of fire fighting services at VA medical centers in the future is limited. Because VA fire departments typically perform a number of non-fire fighting duties. such as inspecting and maintaining fire protection equipment, conducting fire drills, or serving as part of the hazardous response team, in addition to providing fire fighting services at their medical centers, the actual cost for their fire fighting services is significantly less than the cost to establish an outside

source for this service. This cost differential has been documented by the numerous A-76 cost comparison studies.

VA policy is meant to ensure an adequate level of fire fighting response for buildings housing patients overnight and reflects nationally-accepted practices. There are no Federal laws or regulations or other fire codes or standards requiring VA to establish, operate or maintain in-house fire departments.

A typical VA in-house fire department is staffed with 15 FTEE, including a fire chief to provide a minimum of 4 fire fighters on duty for each tour of duty. VA maintains a up-to-date fleet of fire pumpers with sufficient pumping capacity and equipment. Each in-house VHA fire department has, as a minimum, a fire pumper that is less than 17 years old with the average age being 8 years old. VHA has a Fire Department Program Manager who coordinates the activities of the VA fire department program.

While VA continues to pursue options which would enable us to focus on the primary role of proving health care to our patients, the Department remains dedicated to ensuring a safe environment for our patients, employees and visitors.

Vandalism at National Memorial Cemetery of the Pacific (NMCP)

In the late evening of April 19 and early morning of April 20, 1997, the National Memorial Cemetery of the Pacific, or “The Punchbowl,” was one of seven cemeteries in the State of Hawaii to be desecrated by vandals. Vandals spray painted profane and racist words on all 22 walls in the Columbarium Courts and desecrated the Chapel, grave markers, railings and walls throughout the cemetery. Neither the Federal Government nor VA appeared to be specific targets of the vandals as the unauthorized entry by an unknown number of persons affected VA, State and private cemeteries.

The attack on NMCP, the Kaneohe State Veterans Cemetery and several private cemeteries on Oahu was organized, as vandals used stencils and red spray paint to publicize their racist and hateful messages. The cost of repairs at NMCP was estimated at $20,000, donated by the Paralyzed Veterans of America. I am pleased to report that the damaged areas in NMCP have been restored and all graffiti has been removed. Federal, state and local law enforcement officials continue to work together and are still seeking the suspects.

Mr. Chairman, this concludes my prepared statement. My colleagues and I will be happy to answer any questions.